



EMERGENCY INFORMATION SHEET

STUDENT AMBASSADOR PROGRAMS

This form is to be completed thoroughly by an adult.

Ambassador's name _____
last first middle

Address _____
street city state zip code

Father's/legal guardian's full name _____

Father's/legal guardian's cell phone (_____) _____

Father's/legal guardian's work phone (_____) _____

Father's/legal guardian's work address _____
street city state zip code

Father's/legal guardian's work hours _____

Mother's/legal guardian's full name _____

Mother's/legal guardian's cell phone (_____) _____

Mother's/legal guardian's work phone (_____) _____

Mother's/legal guardian's work address _____
street city state zip code

Mother's/legal guardian's work hours _____

Parents'/legal guardians' home phone (_____) _____

Home fax (*if available*) (_____) _____

Parents'/legal guardians' email _____

Please list all medications (over-the-counter and prescription) that you anticipate your child will have in his/her possession on the program. Include aspirin, etc.

Physician's name _____

Physician's address _____
street city state zip code

Physician's phone (_____) _____ Physician's fax (_____) _____

Other Contacts

Please furnish three (3) additional names of people you would feel comfortable with us contacting in the event that you are unavailable.

1. Name _____

Relationship _____

Address _____
street city state zip code

Home phone (_____) _____ Work phone (_____) _____

Fax (if available) (_____) _____ email _____

Work hours (if applicable) _____

2. Name _____

Relationship _____

Address _____
street city state zip code

Home phone (_____) _____ Work phone (_____) _____

Fax (if available) (_____) _____ email _____

Work hours (if applicable) _____

3. Name _____

Relationship _____

Address _____
street city state zip code

Home phone (_____) _____ Work phone (_____) _____

Fax (if available) (_____) _____ email _____

Work hours (if applicable) _____